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ABSTRACT

This study applied a model for the evaluation of a children's residential treatment center. The conclusions are based on data collected for 22 children at four key points: a community baseline relating to families and prior agency contacts, a residential baseline dealing with the child's reported behavior during the first six weeks at the center, the child's behavior at the time of discharge, and the child's subsequent adjustment to the community following discharge. Particular emphasis is given to goal attainment at discharge, and to subsequent goal maintenance as the child reenters and functions within his/her home, school and community milieu. The paper argues for the necessity of supportive personnel, and/or agencies in fostering the child's reintegration in the family, school, and community in general. Procedures of data collection and interpretation are briefly outlined, as well as the inherent problems which arose in the implementation of the model.
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THE APPLICATION OF A RESIDENTIAL TREATMENT EVALUATION MODEL

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Particular emphasis is given to goal attainment at discharge, and to subsequent goal maintenance as the child reenters and functions within his/her home, school and community milieu. The paper argues for the necessity of supportive personnel, and/or agencies in fostering the child's reintegration into the family, school, and community in general. Procedures of data collection and interpretation are briefly outlined, as well as the inherent problems which arose in the implementation of the model.

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A RESIDENTIAL TREATMENT EVALUATION MODEL

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This study reports on the application of an evaluation model which was developed for a children's residential treatment center (1). The facility studied is involved in both community and residential programs. The focus of the community (extramural) program is the organization and development of community resources. The residential (intramural) program provides intensive care for children with severe behavioral problems or mental retardation and includes a residential school. The treatment team has three members--the extramural person, the cottage person, and the school person--all communicating with each other and the patient. The extramural person assumes the role of coordinator, integrating all of the activities and services both within Adler and in the community (2). Two of the three cottages at the center deal with children who are labeled emotionally disturbed and they were the focus of this study. The age range in these cottages goes from 6 to 14. This critical issue was the maintenance of the progress attained on the cottage to the community at discharge and the delineation of those factors relevant to that objective. It was hypothesized that services focusing on that issue of community maintenance could range from parental training and involvement to the determination and development of appropriate after-care facilities.

Consistent with the community goal, maintenance would be the importance of understanding the child's particular environment and consequent life style. In so doing, the behavior of the child was viewed as being transactional. Behavior was seen as a function of the child in a situation (interrelationship) at a particular time where an alteration in the relationship or the situation or the time would in fact alter the behavior.

On the basis of behavior which occurs in a community and is labeled as deviant and unmanageable in relation to parents and/or teachers and/or courts at a particular time, a child or adolescent is recommended for treatment in a residential center. The child then is not inherently deviant, but rather, is deviant in relation to the system of decision makers at a time when his particular style of behavior is not tolerated. This can be referred to as a transactional perspective based on social psychological processes (3).

A child learns how to deal with and adapt to the family system within which he is born. The family system also adapts to include its new members. The child as an interdependent member of that system develops his behavior and subsequent life-style as a function of that system. This is consistent with the ecological perspective of Kelly (4), who said,

Behavior is not viewed as sick or well, but is defined as transactional--an outcome of reciprocal interactions between specific social situations and the individual. Adaptive behavior then can be expressed by any individual in a restricted number of social settings or in a variety of environments and can vary from time to time, as well as from place to place. The research task is to clarify the precise relationships between individual behavior and social structure that differentially affect various forms of adaptive behavior.

This is a process view of actors in a setting where, by acting, both the actors and setting change. The point of primary consideration in this study is that the residential treatment center is a different setting with different situational components and is a different social structure than the community; therefore, the events in a transactional sense are dissimilar. In fact, the behaviors emitted in the community situation will not necessarily occur in the treatment center, and behaviors emitted while in residence may never have occurred prior to admission. On the basis of these concerns, a four-step evaluation plan was developed.

Step 1. Community Baseline

The concern in this step is to accumulate information relative to the child's functioning within the community system before entrance to Adler. The sub-systems of primary concern would be the family and school. The question of import in this state is "What was the child's history before Adler?"

Step 2. Residential Baseline

Because we assume that behavior is situationally determined, it becomes relevant to ask whether the "deviant" behaviors observed in the community (and for which the child has been admitted to a treatment facility) can be elicited in the residential setting. If they do not occur when the child is removed from the community setting, they are inaccessible to modification outside of that setting (at least to those relying on behavioral methods of treatment). Two questions were of import in this step: (1) Was there any difference in behavior exhibited on cottage as compared to behavior exhibited in the community? and, (2) What were the goals selected for treatment?

Step 3. Behavior at Time of Discharge

Residential personnel will want to rate the progress the child has made

at their facility. They will want to compare his residential baseline behavior with his behavior during the period immediately preceding discharge. The question of import in this step is "What percentage of goals was reached at discharge?"

Step 4. Community Follow-up

The question asked here is "How well is the child able to be reintegrated back into the community situation?" That question was measured by determining the number of goals maintained at follow-up.

Most evaluations are limited to Steps 2 and 3. However, when viewing behavior from the transactional system model advocated here, Steps 1 and 4 become crucial. In fact, evaluation concerning effectiveness of treatment at every level must focus upon and show an appreciation of the network of systems from which the individual developed his particular style of life and behavior patterns. (1)

Sample Studied

The Adler Center admitted its first child for residential care on November 1, 1967. Until the present time, November 14, 1973, 255 behavior problem children have been admitted for residential treatment for which comparative demographic data for 191 of these children are available. (Note: These 191 children received services from the Adler Center between January 1, 1966 and December 31, 1972).

The present study selected 22 emotionally disturbed or behavior problem children who appeared on the weekly census of January 17, 1973. The sample of 22 children was matched against the population of 191 to determine how representative they were of general Adler patient population.

With respect to sex, the sample is quite similar to the general population with 82% of the sample as opposed to 80% of the population being male.

The sample was slightly weighted toward white children with the sample having 91% white and the population containing 76% white children. In terms of income, the two groups are quite similar with the average incomes being \$6113.63 and \$6391.12 for the sample and population, respectively.

Slightly over a quarter of the sample received Public Aid assistance as opposed to one-third of the children in the population. The parents of our 22 children in the sample have occupations quite similar to those of the population with the exceptions of craftsmen, laborers, managers, and service personnel.

Grade level at admission differentiated the two groups with respect to only one category, grades 4, 5, 6, and was higher for the sample studied.

Results

Step 1 What was the child's history before Adler?

The average age for an inpatient at Adler is 10.38 years. However, before residence each child has had some mental health agency experience. In fact 15 of 19 of these children for whom that data was available, began their agency careers at or below the age 6 (the other 3 began at ages 7, 8 and 10). Five children had one agency experience, nine had seen two, three had seen three, and five had been to four agencies before Adler.

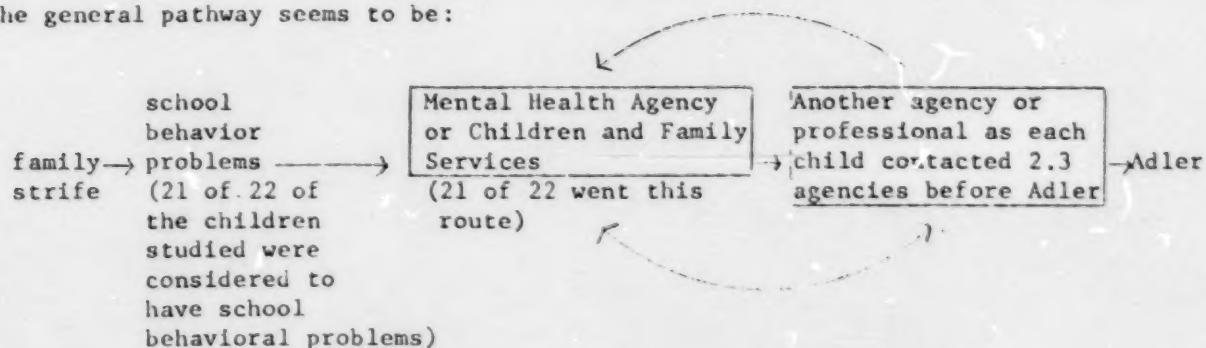
Fifteen of the children had been to a mental health center for at least one treatment procedure (time data for length of sessions of treatment was not available) four had been to both a Children and Family Services Agency and a mental health center and one to a Children and Family Service Agency only. Only one child didn't have any contact with either a mental health center or children and family service. That child was referred to Adler directly from a school psychologist.

Not enough data is known about these children to determine whether the disruptive, aggressive or isolative behavior they exhibited was a function of coping and subsequent adaptation to their family system. Unfortunately, data with the detail that would be required is not available. All that can be said is that 15 families (or head of household) reported difficulty in dealing with their children - before the children went to any agency and before they attended school. Often these problems seemed a function of the marital conflicts - but now we go beyond the data.

In any case, three critical points occurred with every child: (1) family conflict, (2) school behavioral problems, (3) then referral to several mental health professionals or agencies, with no service being effective in halting the child's mental health career which eventually came to Adler Center.

It's clear from this sample that the child's mental health agency career started in the school system. Twenty of the twenty-two children were referred to a mental health agency from the school because of aggressive disruptive behavior in the school. It is also equally clear that these difficulties were being experienced by parents in the home before and during the child's school experience.

The general pathway seems to be:



Five of the 22 children had minimal or no support systems (i.e. family). One father deserted and mother has been hospitalized in a state mental

institution 16 times since the child's birth. Another mother deserted her child when he was 2. A third gave their son to an aunt and uncle because she felt incapable of handling him. The father of the fourth abandoned the home and mother has been labeled psychotic and is currently being treated as an out-patient at a state mental hospital. The fifth's parents wanted to give up legal custody - since they can't handle him in the home environment. Briefly then, these 5 children were defined in a category labeled simply - non-support (N.S.).

The remaining 17 children were classified as having support system although this occurred in varying degrees. The focus in treatment was not only to work on specific goals in the cottage but to elicit parental involvement in some aspect of the child's program. For some parents that involvement was easy to evoke, for others impossible.

It should be pointed out here that while the separation of the children into support and non-support groups was, to us, a justifiable dichotomy, it would probably be more accurate to establish a continuum from support to non-support situations. We, however, had no quantifiable basis for which to establish fine discriminations. It was not the initial intent of this study to make these categorizations but we did so to provide some clarification. All conclusions focusing on differentials between support and non-support groups must be undertaken with some reservations.

Step 2 Was there any differential behavior patterns on cottage as compared to community?

Over two-thirds of the children studied, or 15, exhibited some degree of behavioral and/or emotional change during their first six weeks on the cottages. Such behaviors were in contrast to those exhibited in the children's homes, schools or communities. These differential reactions ranged from

marked increases in intensity of aggressive and/or destructive behaviors to what might be labeled a "honeymoon effect". This effect can be defined by those behaviors which either dropped out or decreased in intensity for a short period of time, e.g. between one and six weeks which may have been a result of the child's extrusion from his community rather than any treatment provided on the cottage. (Rates of intensity and/or duration are not available. These conclusions are based upon the judgments of cottage staff who were interviewed by the present authors.)

This honeymoon effect was observed in thirteen of the fifteen children. In the case of one child, his counselor reported that John had a "honeymoon period" wherein his behavior was quite good. The bed-wetting behavior reported prior to admission was not evident at the cottage. However, shortly thereafter non-compliant tantrumming and isolative behaviors returned. Another child who was reported to have continually played with matches and whose hygiene was quite inadequate prior to admission, reacted to Adler both by rapid improvement in hygienic skills and a complete remission of fire-setting behaviors. His counselor commented that these sudden changes probably were the result of a high degree of structure on the cottage.

For two children increases in intensities of behaviors were reported by cottage staff. One child was reported to have become highly physical in expressing aggression toward others. This behavior may have represented a rebellious lashing out at the high degree of structure present on the cottage which seems in marked contrast to a possible suppression of such behavior by those children exhibiting the "honeymoon effect." Changes in three areas were evident for another child who according to a staff member may have been reacting to the baseline data collection techniques. He ate only minimal amounts of food on the cottage as opposed to normal or excessive

portions at home. He performed quite low at the Residential School in contrast to his performance in a community EMH class, and the amount of verbalization dropped significantly.

No indicated changes in behavior were reported for seven of the twenty-two children. Either these children did not differentiate between their communities and our facility, or they determined that their previous modes of interaction would be appropriate at Adler.

As previously discussed in this paper, the children were subdivided into two groups: those 17 children receiving community support and those 5 who apparently had little or no support. The following chart further divides these two groups into the three categories of honeymoon effect - remained same and increase.

	<u>SUPPORT</u>	<u>NON-SUPPORT</u>	<u>TOTAL</u>
"Honeymoon effect"	11	2	13
General increase	1	1	2
Same (no change)	5	2	7
TOTAL	17	5	22
	$(\chi^2 = 8.93, p < .02)$	(NS)	$(\chi^2 = 8.22, p < .05)$

The trend indicates that children who exhibited a "honeymoon effect" were more likely to come from or, return to, supportive communities. On the other hand, those children from non-support situations were less likely to exhibit any differentiation between "honeymoon effect", deviant behavior increase or remaining the same. However, the small N would render these statements tenuous (despite the significant χ^2). This finding then represents, at best, a hypothesis for future investigations.

What were the goals that were selected for treatment?

Generally the goals were selected for cottage focus on the basis of the

child's community experiences. The goals were formulated within an operant context which is the primary treatment modality at this facility.

The listing of residential goals set at the Adler School and on the cottage appear to cluster into three basic categories. These include academic related goals, socio-emotional developmental goals, and specific behavioral goals. Academic goals refer to areas of language and arithmetic building skills, or related subjects which require remediation. Socio-Emotional goals make reference to areas of life style changes and self concept (feeling good about oneself). Behavioral goals relate to the reduction or increase of specific observable behaviors. The goals are listed in order of frequency occurrence in order to give an impression of the general problems dealt with.

Insert TABLE 1 about here

Step 3 What percentage of goals were reached at discharge?

Table 2 indicates the number and % of goals reached at discharge.

Insert TABLE 2 about here

Table 2 does indicate that our cottage treatment program was successful in achieving their prestatated goals. The non-support group shows a 76% (20 out of 26 goals) goal attainment (GA) and the support group 85% (77 of 90 goals) with a total of 83% (97 out of 116).

Data on goal maintenance is available for 18 of the 22 children at the time of this writing since two children are still on the cottage and information regarding the remaining two is unavailable due to a reluctance on the part of the parents to provide such data.

Step 4 What is the number of goals maintained at follow-up?

The follow-up aspects of this study are embodied within the conceptual framework of what the authors identify as non-support versus support community systems. A support system was defined as generally including: 1) a home for the child to be placed, which is conducive for the child's maintenance and growth, 2) the involvement of community agents who purposely strive to maintain the child's positive behavior, and 3) a willingness on the part of school and community personnel to initiate new programs where necessary or where others fail. We define a support system more specifically as a reinforcing structure which assists the child in maintaining behaviors which are deemed acceptable to community agents such as parents, teachers, and significant others who are considered a part of the child's immediate milieu. A home support system, for instance, would be defined as one where the child's parent(s) intentionally provide him/her with essential social or token reinforcement so as to elicit appropriate and desired behavior. In like fashion a school support system willingly reinforces and maintains goals that have been set while the child was in residence.

Nonetheless, the authors found that of the 22 children, five were designated a part of a non-support system while the other seventeen were included in some degree of a positive support environment. By degree here, we are suggesting that characteristically speaking support and non-support systems may be viewed on a continuum from very strong support to very weak or no support at all.

The findings of the support versus non-support groups are enlightening. Percentages show that those thirteen children who were part of some supportive system maintained 71% of their goals after discharge from the treatment center. In contrast to this, the five clients who did not have benefit of the support environment but who were non-support cases maintained only 50% of their treatment goals after discharge from the cottage unit. Although our sample is small the authors feel that this is a substantial difference of which the reader should be aware.

Discussion

If we were to base the evaluation on improvement or goal attainment (GA) between admission (Step 2) and discharge (Step 3) the residential treatment has been successful. The non-support group had a 76% GA and the support group showed an 85% GA with a total of 83% GA. Apparently despite prior experiences, or the relative parental and community support given to these children before admission to the residential center, the treatment as measured by the attainment of goals selected was successful.

The follow-up pointed to a steady decrease in the number of goals maintained in the community. The follow-up period ranges from only two to five months after residential care but there was a 50% rate of goal maintenance (GM) in the non-support group and a 71% GM in the support group for an overall total of 66%. A longer period is needed for a more comprehensive assessment of GM, but considering that the time spent in residential care ranged from 6 to 13 months with an average of 9.1 months, a drop in GA from 83% to 66% or a drop in 27% of the goals (15 to 10 for non-support and 68 to 54 for support total goal drop 19 out of 83 or 22%) requires some discussion.

The difference between the support and non-support children may shed some light on the nature of goal maintenance. Just as a controlled trained environment is necessary for treatment it is necessary for the maintaining of the goals achieved in residence. The use of the word "trained" environment deals with an important aspect of treatment. It's more than possible that the child's preadmission environment played a critical role in the development of the child's deviant problem behavior and without that involvement, particularly parental involvement, on cottage treatment may be an exercise in futility.

However, the lesson learned in this study, is that despite a child's prior experiences with mental health agencies, they can, in our residential center be treated successfully when success is measured in terms of goal attainment.

But, the question of principle concern here is, can the evaluation of a residential mental health center be limited to on cottage performance? The inpatient staff are certainly justified in insisting that they can't be responsible for behavior occurring in situations for which they have no control - the post treatment community. In fact, follow-up information on their patients may have no relationship to the on cottage treatment. But behavior change within a controlled environment has limited generalizability and without that carry over to the child's home environment that treatment is of limited value.

Generally, the limitations of this study are pointed to the subjectivity of the data. This is manifested in the definitions of support - non-support groups; honeymoon - non-honeymoon effects; and number of goals attained and maintained. Although most of the goals attained were graphed on the cottage by the inpatient staff, the subjective nature of the interviews does suggest the need for more emphasis on quantification schedules for data collection.

The nature of family structure and functioning need also be defined in more quantifiable terms as that variable is particularly critical. The model was quite useful in systematically analyzing the variants critical to a child's pathways through the agency system. The limitations of our findings were also pointed out clearly through the framework of this model.

TABLE 1

Listing of Residential Goals

<u>Goal</u>	<u>Frequency</u>
Improve peer relations	16
Improve school performance	14
Compliance	8
Decrease aggressive behavior	7
Improve self concept	6
Control temper	5
Significant other goals	5
On task behavior	5
Improve physical skills	4
Express feelings better	2
Improve relations with siblings	2
Reduce baby talk	2
Decrease isolative behavior	2
Improve adult relationships	2
Work on home problems	2
Better use of time	2
Decide on proper medication	2
Reduce seizures	1
Improve meal manners	1
Improve toilet behavior	1
Reduce lying	1
Making constructive life style changes	1
Improve self reliance	1
Lessen anxieties	1
Respect other's property	1
Assume responsibilities	1
Develop Hygiene Skills	1
Extinguish bizarre behaviors	1
Decrease manipulative behavior	1
Reduce bed wetting	1
Increase use of common sense	1
Improve working relations with others	1
Teach rules	1
Reinforce acting age	1
Raise expectations	1
Develop systematic reinforcement	1
Decrease provocations	1
Find appropriate reinforcement	1
Decrease loud talk	1
Set appropriate limits	1
Work on sexual problems	1
Improve self help skills	1
Reduce weight	1

TABLE 2

NON-SUPPORT	Goals Result				Total Number Goals Set On Cottage	Total Number Goals Attained at Discharge	Total Number Goals Maintained at Follow-Up
	Child	Number of Academic Related Goals	Number Goals/ Socio-Emotional Development	Number Goals/ Specific Behavioral			
	1	1	3	2	6	5	ND
	2	0	3	1	4	4	0
	3	1	3	4	8	6	7
	4	0	2	1	3	0	0
	5	2	1	2	5	5	3
					26	20 (76%)	10
					(20)	(15)	(10) (50%)
SUPPORT	6	1	4	1	6	3	2
	7	3	2	3	8	8	7
	8	2	3	4	9	9	9
	9	1	3	0	4	2	3
	10	2	3	0	5	4	5
	11	0	3	3	6	6	4
	12	0	4	0	4	4	4
	13	1	3	2	6	5	4
	14	3	3	2	8	8	3
	15	1	2	2	5	5	5
	16	1	0	3	4	4	4
	17	0	2	4	6	6	ND*
	18	0	2	1	3	3	ND**
	19	1	4	0	5	0	ND**
	20	0	0	4	4	4	4
	21	0	1	2	3	2	0
	22	0	0	4	4	4	0
					90	77 (85%)	54
					(76)	(68)	(54) (71%)
					116	97 (83%)	64 (66%)
						(83)	

*Still on Cottage

**parent refuses to cooperate

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